Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN5974AGC	A. BUILDING _____ B. WING _____	06/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY SENIOR CARE	3645 RIO POCO RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an initial State Licensure survey conducted in your facility on 6/9/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is requesting licensure for nine Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census was zero. One sample resident file was reviewed and one employee file was reviewed.	Y 000		
Y 106 SS=F	449.200(2)(a) Personnel File - 1st aid & CPR NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. This Regulation is not met as evidenced by: Based on interview and record review on 6/9/10, the facility failed to ensure the only caregiver on duty (Employee #1) had completed training in first aid and cardiopulmonary resuscitation (CPR),	Y 106		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 106	Continued From page 1 affecting all residents. Severity: 2 Scope: 3	Y 106		